VACCINE ADVERSE EVENT REPORTING SYSTEM (VAERS)
Patient Identity Kept Confidential

Supplemental Information for Smallpox Vaccine in Pregnancy Registry

Based on field-expedient word-processor template, *version 7 February 03* [based on Form VAERS-1], developed by the Military Vaccines [MILVAX] Agency, U.S. Army Surgeon General's Office, 5111 Leesburg Pike, Suite 401, Falls Church, VA 22041.

Return to birthregistry@nhrc.navy.mil or FAX 619-553-7601, DSN 553-7601
Telephone 619-553-9255 or 619-553-9255. POC: Dr M. Ryan

Other ways to report Vaccine Adverse Events: www.vaers.org, 800-822-7967, PO Box 1100, Rockville, MD 20849-1100

Clinical consultation on vaccination issues may be referred to the Vaccine Healthcare Centers, www.vhcinfo.org , 202-782-0411

These data will be used to increase understanding of adverse events following vaccination and will become part of Centers for Disease Control and Prevention Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems." Information identifying the person who received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee or legal representative.

Patient Name:
Patient SSN:
Patient date of birth:
Patient military rank and branch of service:
Patient address [military unit and location]:
Email and/or phone:

Form completed by:
Relation to patient:
Email and/or phone:
Date form completed:

Date smallpox vaccination given:
Facility name/location:

Date smallpox vaccine "take" assessed:
Was "take" evident? Yes No

Was pre-vaccination screening form completed? Yes No *[If Yes, please provide copy]*
Did patient express concern about pregnancy at screening visit? Yes No
Was pregnancy test done on day of vaccination? Yes No

Date pregnancy diagnosed:

Date of last normal menstrual period:

If ultrasound used for gestational age, provide results:

Method of birth control used at time of conception, if any:

Number of previous pregnancies:
List outcomes (with dates) of any previous pregnancies.

Was this the first smallpox vaccination for this patient? Yes No
If No, please provide approximate date(s) of any previous smallpox vaccinations.

Were any other vaccines administered during this pregnancy? Yes No
If Yes, please list other vaccines and dates administered:

Medical facility where patient will be followed (name/address/phone):